STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey	F 000		
F 226 SS=C	LICENSURE SURVEY FOR SUBPART S: SMI 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure that work histories and references were checked for 10 new employees (E12 - E21) of 10 new employee files reviewed. This had the potential to effect all 82 residents in the facility. The findings include: 1. Ten Certified Nursing Assistant (CNA) files (E12 - E21) hired between 6/20/11 and 10/25/11 were reviewed on 11/2/11. The files included applications which listed their work histories and references. There was no documentation that any of the work histories or references had been checked in the ten files. 2. On 11/2/11, E1, Administrator, was asked if there was any evidence that work or personal references were check in the files and he said there wasn't. 3. The facilities Abuse Prevention Program	F 226		11/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

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NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

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F 226	Continued From page 1 Facility Policy documented under the section Pre-Employment Screening of Potential Employees that the facility will initiate a reference check from previous employers. 4. A review of the Resident Census and Conditions of Residents form dated 11/1/11 documented the facility has 82 residents.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Care Plans address individualized needs for 4 of 17 residents (R1,	F 279		11/18/11

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	145928	A. BUILDING _____ B. WING _____	11/04/2011

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F 279	Continued From page 2 R2, R3 and R4) reviewed for care plans in the sample of 17. Findings include: 1. It is documented in R3's Hospital and Physical Examination of 9-23-2010, R3 has a diagnosis of Spina Bifida and was hospitalized in the last month for small bowel obstruction. Nurse Practitioner Note of 3-28-11 documents R3 has Chronic Constipation. Hospital History and Physical of 7-26-11 documents Chronic constipation. Hospital X ray report of 7-26-11 shows mild ileus was seen with the fecal impaction in the colon. Hospital Emergency Department report of 8-7-11 documents diagnosis of Constipation. Chief complaint is documented as abdominal pain for 4 days. Much worse today. No bowel movement (BM) for 5 days until yesterday with small hard stool. Past medical history includes small bowel obstruction. Abdomen tenderness, some high pitch and some distention. Clinical Impression is abdominal pain - resolved constipation. On 11-2-11 at 9:30AM, E2, Director of Nursing (DON) stated R3 is at increased risk for constipation and fecal impaction due to Spina Bifida and taking pain medications. There is nothing on R3's Care Plan of 10-10-11 that address R3 having a history of Constipation or Fecal Impaction. 2. R2's Minimum Data Set (MDS), dated 9-23-11, documented R2's diagnoses as, in part, Senile Dementia and Schizophrenia. R2 requires extensive assistance of one person physical assistance with toileting and walking in her room and corridor.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

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F 279	Continued From page 3	F 279		

R2's Incident Summary, dated 10-13-11, documented R2 was found on the floor by her roommates bed. It was also documented that R2 had a laceration to the left side of her forehead and a hematoma to her forehead. R2's Incident Summary, dated 10-16-11, documented R2 was found on the floor in her bathroom. It was also documented that R2 was admitted to a local hospital. R2's chart documented R2 was re-admitted to the facility, on 10-20-11, with a fractured right hip.

R2's Care Plan, goal dated 10-31-11, documented R2 was at risk for falls related to self care deficits and impaired cognition and impaired mobility. R2's Care Plan did not document her 10-13-11 and 10-16-11 falls and fall prevention interventions for her falls.

In an interview with E3, Director of Nursing (ADON), on 1-3-11 at 9:45a.m., E3 stated R2 was confused and had a history of attempting to ambulate without assistance and self-toileting. Interview with E7, Certified Nursing Assistant (CNA), on 11-4-11 at 11:00a.m., E7 stated R2 had a history of trying to get up and walk around before her falls. Interview of E14 (CNA), on 11-4-11 at 11:05a.m., E14 stated R2 had a history of trying to get up all the time before her falls.

3. On 11/01/11 at 10:23 AM, R4 was observed on the floor in the bathroom in front of the toilet in his room as a result of an unwitnessed fall. Upon review of R4's record, it was determined that R4 has had nine unwitnessed falls with varying injuries since March, 2011, six of those falls since 10/17/11.

The MDS, dated 08/05/11, identified R4 as moderately cognitively impaired with short and

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	145928	A. BUILDING _____ B. WING _____	11/04/2011

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NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

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F 279	Continued From page 4 long-term memory deficits, needs extensive assist of at least one staff person for all transfers, ambulation, dressing, hygiene and bathing. The care plan, last updated 08/23/11, identified R4 as a risk for falls due to "impaired cognitive and safety awareness...nonambulatory...receive meds which increase risk for falls." The interventions for the following falls, dated 10/17/11, 10/24/11, 10/27/11 and 10/30/11, were to refer to PT/OT. The interventions for the falls, dated 11/01/11, were to have frequent checks and 72 hour charting. There was no documentation to indicate that the facility had conducted any new assessments for causative factors that had led to the recent falls and incorporated those factors into an updated individualized care plan.	F 279		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assess and monitor 1 of 1 resident (R3) reviewed for constipation in a sample of 17. This failure resulted in R3 being hospitalized with fecal impaction. Findings include:	F 309		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

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F 309	Continued From page 5	F 309		

1. It is documented in R3's Hospital and Physical Examination of 9-23-2010, R3 has a diagnosis of Spina Bifida and was hospitalized in the last month for small bowel obstruction. Nurse Practitioner Note of 3-28-11 documents R3 has Chronic Constipation. Hospital History and Physical of 7-26-11 documents R3 's chief complaint is fever, abdominal pain, nausea and vomiting. It is documented under Assessment and Plan, in part, Chronic constipation. Hospital X ray report of 7-26-11 shows mild ileus was seen with the fecal impaction in the colon. Hospital Emergency Department report of 8-7-11 shows R3 was in the Emergency Room with a diagnosis of Constipation. Chief complaint is documented as abdominal pain for 4 days. Much worse today. No bowel movement (BM) for 5 days until yesterday with small hard stool. Past medical history includes small bowel obstruction. Abdomen tenderness, some high pitch and some distention. Clinical Impression is abdominal pain - resolved constipation.

R3's November 2011 Physician Order Sheet (POS) documents a diagnosis, in part, Schizophrenia, Pain, and Constipation. R3 has an order for Morphine Sulfate 15mg daily, Senna Plus twice a day, Bisacodyl 10mg every 8 hours if no bowel movement in 3 days. (Facility BM Tracking Records show the facility is not routinely documenting when R3 has a BM).

R3's Nurses Notes of 8-3-11 states R3 has complaints of constipation and has been refusing Miralax but agreed to take to have a BM. There are no further Nurses Notes addressing BM until 8-6-11 at 2200 stating R3 complaining of abdomen pain but refusing treatment. Large, soft BM noted. Note of 8-7-11 at 1530 documents R3 approached writer with complaint of pain to lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6	F 309		

right abdomen that radiates to lower back, is constipated with "rock solid pebbles" in stool. R3 became tearful and stated pain has increased. R3 agreed to be seen by a Doctor and was sent to the ER. Note at 2100 states R3 is back from ER with a diagnosis of Constipation. New order for Mag Citrate one bottle by mouth now and repeat dose tomorrow at bedtime if no good results.

Facility BM Tracking records for August 2011 show no BM recorded until 8-8-11. Records show documentation of 6 BM's in the month of August. BM record for September 2011 show documentation of 1 BM and October 2011 shows documentation of 3 BM's for the month.

On 11-2-11 at 9:30AM, E2, Director of Nursing (DON) stated R3 is at increased risk for constipation and fecal impaction due to Spina Bifida and taking pain medications.

B) Based on observation, interview and record review, the facility failed to assess, monitor and treat pain for 1 of 6 residents (R2) reviewed for pain in the sample of 17. This failure resulted in R2 crying with pain.

Findings include:

R2's Minimum Data Set (MDS), dated 9-23-11, documented R2's diagnoses as, in part, Senile Dementia and Schizophrenia and extensive assistance of one person physical assistance with toileting and walking in her room and corridor.

R2's Incident Summary, dated 10-13-11, documented R2 was found on the floor by her roommates bed. It was also documented that R2 had a laceration to the left side of her forehead and a hematoma to her forehead. R2's Incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

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F 309	Continued From page 7	F 309		

Summary, dated 10-16-11, documented R2 was found on the floor in her bathroom. It was also documented that R2 was admitted to a local hospital. R2's chart documented R2 was re-admitted to the facility, on 10-20-11, with a fractured right hip.

R2's Pain Screening Form, dated 10-20-11, documented R2's score as a 14 and "score 5 or greater indicates comprehensive assessment needed. R2's Comprehensive Pain Assessment was not dated or completed.

Interview of E11, Care Plan/MDS Coordinator, stated on 11-3-11 at 10:30a.m., R2's Comprehensive Pain Assessment had not been done.

R2's PRN (as needed) Medications sheet, dated 10-20-11 to 11-19-11, documented R2 was administered "Ultram 50mg...pain" 10-26-11 at 1600, 10-27-11 at 1600, 10-28-11 at 12noon and 1600 and 10-31-11 at 12noon. R2's PRN Medications sheet did not document the reason for administering the medication, site of pain and the result of the medication administration. R2's PRN Medications sheet, dated 11-1-11 to 11-30-11, documented R2 was administered "Ultram 50mg...for pain" on 11-1-11 at 1230 and 1630 and on 11-2-11 at 1545. R2's Nursing Notes, dated 11-1-11 and 1-2-11 and PRN Medication sheet did not document the reason for administering the medication, site of pain and the result of the medication administered.

R2 was observed, on 11-2-11 at 12:00 noon, sitting in the dining room with a weepy, tearing right eye that she repeatedly blinked. R2 was observed until 3:20p.m. repeatedly blinking her right eye which continued to drain.

Interview of R2, on 11-2-11 at 3:20p.m., R2 nodded her head up and down when asked if her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

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F 309	Continued From page 8 right eye hurt. Interview of E7, Certified Nursing Assistant (CNA), on 11-4-11 at 11:05a.m., E7 stated R2 answered questions by nodding her head up and down for yes. Interview of E8, Licensed Practical Nurse (LPN), on 11-2-11 at 3:20p.m., E8 stated R2's eye was weepy and that R2 indicated she was in pain. E8 also stated she would contact R2's physican. R2's PRN Medication sheet, dated 11-1-11 to 11-30-11, documented R2 was administered "Ultram 50mg..for pain" on 11-23-11 at 1545 but the reason for administering the medication, site of pain and the result of the medication administered. R2's Nursing Notes, dated 11-1-11 to 11-3-11, did not document R2's physician was called for R2's right eye or the effectiveness of the administered medication. The facility's Pain Management policy and procedure, dated 9-02, documented the first step in pain management was assessment and to assess and documented at regular intervals after initial treatment plan and at suitable interval after each pharmacologic or nonpharmacologic intervention.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced	F 322		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 9	F 322		

by:
Based on record review, observation and interview, the facility failed to document nutritional intake for 1 of 1 residents (R13) reviewed for gastronomy feeding with weight loss in the sample of 17.

Findings include:

R13's Minimum Data Set (MDS), dated 8-26-11, documented severe cognitive impairment, total dependence of one person physician assistance with eating and fluids and a feeding tube for a nutritional approach. R13's Routine Medication Sheets, dated 11-1-11 to 11-30-11, documented R13 was administered "Jevity 1.2 liquid run at 70ml per hour x (times) 18 hours" to be administered from 5:00a.m. to 11:00p.m. daily.

The facility's Intake and Output Recording (Fluid Balance Monitoring) Policy and Procedure, not dated, documented "the purpose is to provide an accurate record of the resident's fluid intake and output." It was also documented "g. 24 hours total are recorded on the appropriate resident clinical record forms by the licensed nurse."

R13's Routine Medication Sheets did not document an Intake and Output Record for November, 2011.

Interview of E3, Assistant Director of Nursing (ADON), on 11-3-11 at 11:10a.m., E3 stated R13 did not have a November Intake and Output Record.

R3's Intake and Output Records, dated 1-21-11 to 7-5-11 and as provided by E2, Director of Nursing, documented, in part, "NPO" (nothing by mouth) and not an amount of tube feeding. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

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F 322	Continued From page 10 was also noted R13's daily intakes were not consistently documented as either no entries to 700 cc of intake in a 24 hour period. R3's Monthly Record of Vital Signs, dated 2010 and 2011, documented R3's weight loss as 150 pounds in 10-10, 149 pounds in 12-10, 145 pounds in 1-11, 146 pounds in 2-11, 139 pounds in 3-11, 135 pounds in 4-11, 138 pounds in 5-11, 136 pounds in 6-11, 135 pounds in 7-11, 136 pounds in 8-11 and 136 pounds in 9-11. R13's Significant Change Nutritional Assessment, dated 3-30-11, documented R13's ideal body weight as plus or minus 135 pounds.	F 322		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to revise and implement effective interventions for prevention of repeated falls 3 of 6 residents (R1, R2, R4) reviewed for falls in a sample of 17. Findings include: 1. On 11/01/11 at 10:23 AM, during the tour of the 100 hall, R4 was observed in his room on the floor in front of the toilet with a wheelchair at his	F 323		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

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F 323	Continued From page 11	F 323		

side. E23, Social Services Director, stated that R4 has been getting up on his own and falling lately. R4 was alert, but not oriented, in which E23 reported that is normal for R4. At 10:26 AM, E4, Licensed Practical Nurse, (LPN), assessed R4 for injuries and found no obvious signs of injury. E22 (Restoratives PT) and E6, Certified Nurse Aid, (CNA) then assisted R4 up to wheelchair and transferred R4 to bed. While E6 (CNA) was performing incontinent care, it was observed that R4 had multiple bruises to his left side from the upper ribs down to mid thigh in varying stages of healing. E4 (LPN) stated that the bruises were caused from R4 having so many falls lately. On 11/11/11 at 10:30 AM, E22 stated, "He is supposed to be a walk to dine, but lately I haven't been walking him because he has fallen so much the past few days."

R4 was admitted on 07/18/97 and has medical diagnoses, in part as, dementia, Alzheimer's Disease, epilepsy and seizure. The Minimum Data Set (MDS), dated 08/05/11, identified R4 as moderately cognitively impaired with short and long-term memory deficits, needs extensive assist with at least one staff person for all transfers, ambulation, dressing and hygiene and bathing. It also identified R4 as occasionally incontinent of bowel and bladder. The care plan, last updated 08/23/11, identified R4 as an increase risk for falls due to "impaired cognitive and safety awareness...nonambulatory...receive meds which increase risk for falls..." The Falls Risk Assessment, dated 08/05/11, identified R4 scoring 18 points which indicates he is at high risk for falls.

The Fall Prevention Program policy and procedure was reviewed on 11/04/11. Under, "#10. Care incorporates: c. Interventions are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

changed with each fall, as appropriate, and d. Preventative measures. #12. b. Recommendations for changes in the plan of care to minimize reoccurrence."

On 03/11/11 at 12:30 PM, the Incident Summary documented that R4 was found on the floor by another resident. R4 was found "lying on the floor face lying in blood, blood coming from nose and head." R4 was sent to hospital for treatment for head laceration and left leg pain. There were no new or revised interventions put into place on R4's care plan. On 03/15/11 at 5:55 AM, the Incident Summary documented that R4 was on floor between bed and dresser and wheelchair. The care plan, dated 03/15/11, documented "refer to PT/OT for strengthening."

On 07/16/11 at 11:00 AM, the Incident Summary documented that R4 was found on the floor in his room. It further documented "It appears he was attempting to transfer from chair to bed." The intervention on the care plan, dated 07/16/11, documented "Ensure I am wearing proper footwear before transfers."

On 10/17/11 at 5:30 PM, the Incident Summary documented "Found on floor sitting up..." The intervention, dated 10/17/11, documented "refer to restorative CNA for poss strengthening, P/O (PT Physical Therapy/OT Occupational Therapy)." On 10/24/11, the Incident Summary documented "went to room after eating supper and tried to transfer self, became weak in legs and sat on floor." Interventions documented on the care plan were "PT/OT screen." No new interventions documented on the care plan. On 10/27/11, the Incident Summary documented "Resident roommate informed writer that this resident on floor. Resident sitting on bottom in bathroom with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

wheelchair behind him." Interventions documented on the care plan for 10/27/11 "PT/OT continue." On 10/30/11 at 5:30 AM, the Incident Summary documented "found on floor between bed and wheelchair. Resident was transferring self. Wheels on wheelchair locked." Interventions on the care plan, dated 10/30/11 "PT/OT."

On 11/01/11, the Incident Summary documented two separate unwitnessed falls. One at 10:23 AM, and the other at 12:30 PM. The Incident Summary documented at 12:30 PM, "observed on floor next to bed trying to lie down." The interventions documented "frequent checks and 72 hour charting."

2. R2's MDS, dated 9-23-11, documented R2's diagnoses as, in part, Senile Dementia and Schizophrenia and extensive assistance of one person physical assistance with toileting and walking in her room and corridor.

R2's Incident Summary, dated 10-13-11, documented R2 was found on the floor by her roommates bed. It was also documented that R2 had a laceration to the left side of her forehead and a hematoma to her forehead. R2's Incident Summary, dated 10-16-11, documented R2 was found on the floor in her bathroom. It was also documented that R2 was admitted to a local hospital. R2's chart documented R2 was re-admitted to the facility, on 10-20-11, with a fractured right hip.

R2's Care Plan, goal dated 10-31-11, documented R2 was at risk for falls related to self care deficits and impaired cognition and impaired mobility. R2's Care Plan did not document her 10-13-11 and 10-16-11 falls and fall prevention interventions for her falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14	F 323		

Interview of E3, Director of Nursing (ADON), on 1-3-11 at 9:45a.m., E3 stated R2 was confused and had a history of attempting to ambulate without assistance and self-toileting. Interview of E7, Certified Nursing Assistant (CNA), on 11-4-11 at 11:00a.m., E7 stated R2 had a history of trying to get up and walk around before her falls. Interview of E14 (CNA), on 11-4-11 at 11:05a.m., E14 stated R2 had a history of trying to get up all the time before her falls.

Interview of E11, Care Plan/MDS Coordinator, on 11-3-11 at 9:20a.m., E11 stated R2's Care Plan was in the "down file". E11 provided an updated fall Care Plan on 11-3-11 on placed in R2's Chart. R2's updated fall Care Plan documented R2 was referred to Physical Therapy/Occupational Therapy after her 10-13-11 and 10-20-11 falls. R2's fall prevention Care Plan did not document R2's history of attempting to self ambulating or new interventions to prevent falls as a result of her self ambulating. R2's chart did not document assessments or causative factors of R2 falls.

3. R1's MDS, dated 4-29-11, documented, diagnosis, in part, as Cerebral Palsy, no signs and symptoms of Delirium, no short or long term memory problems, total dependence of two plus persons physical assistance with transfer and bilateral functional limitation in range of motion for upper and lower extremities. Interview of E3 (ADON), on 11-1-11 at 10:00a.m., E3 stated R1 was reliably interviewable.

R1's Preliminary 24-hour Incident Investigation Report, dated 7-5-11, documented R1 complained of right ankle swelling on 7-4-11 a 10:30a.m. and a portable X-ray revealed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15 fractured of the distal fibula. Interview of R1, on 11-2-11 at 2:35p.m., R1 stated a staff member, name not stated, caught her right foot in her reclining chair during a transfer. She also stated her right foot was broken during the transfer. R1's Final Incident Investigation Report, dated 7-7-11, documented "all nursing staff have been re-inserviced regarding proper transfers include Hoyer lifts, transfers et techniques."	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to administer medications at the time ordered. There were 42 opportunities with 3 errors resulting in a 7.10% medication error rate. The errors involved 3 residents (R5) in the sample of 17 and 2 of 2 residents (R18 and R19) in the supplemental sample. Findings include: 1. During observation of the medication pass, on 11-3-11 at 8:30a.m., E4, Licensed Practical Nurse (LPN), did not pass the following scheduled 8:00am medications: a) R18's physician ordered, order date 7-29-11, daily "KlorCon M 20mg"; and, b) R19's physician ordered, order date 10-21-11, twice	F 332		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 16 daily "Os-Cal 500 with 200mg D". Interview of E4, on 11-3-11 at 8:30a.m., E4 stated R18 and R19's medications were not available and that she would call for additional medications. E4 also stated R18 and R19 medications had not been administered on 11-1-11, 11-2-11 and 11-3-11. 2. During medication pass on 11-2-2011 at 12:10PM, E4, LPN, failed to give R5 her Alphagan eye drops. According to R5's POS, R5 is to receive Alphagan 0.1%, 1 drop to right eye three times a day, including noon med pass. On 11-2-11, E4, LPN, initialed she had given the eye drop. When E4 was told she did not give the eye drop during medication pass, E4 looked in the medication cart and could not find the eye drops. E4 stated she should have circled the medication was not given On 11- 3-2011 at 8:40AM, E2, DON, stated R5 had thought the eye drop had been discontinued. E2 stated she had called the doctor and the eye drop had not been discontinued. E2 confirmed R5 had not been receiving the eye drop. On 11-4-11 at 11:58AM , E2 and E3, Assistant Director of Nursing both stated R5's doctor wants her to have the eye drop. Both stated they did not know if the eye drop was in the facility.	F 332		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to assure that foods are served at palatable temperatures, in the South Dining Room on the second shift, for 2 of 17 residents (R7, R11) reviewed for dining in the sample of 17 and 3 residents (R21,R22, R23) in the supplemental. The findings include: 1. During the group meeting on 11/2/11 at 10:00 AM with 10 residents in attendance, they were asked about the food being served at the facility. Several spoke up and said the hot food was cold sometimes when served. R11, R21, R22 and R23 were in attendance and complained about the cold food and said they ate on the second shift in the South Dining Room. 2. At 12:20 PM on 11/2/11 staff were asked if all the residents had received their trays off the cart. They said they had. One of the trays on the cart was for R23 who had been transferred to the hospital. The temperature of the pork fritter was 115 degrees Fahrenheit (F) cream style corn 122 F and mashed potato was 115 F. The plate cover did not fit properly to provide a seal to prevent heat loss. Other plates on the cart were observed and were also found to covers that did not fit the plates properly. Other plates did not have covers but were covered with aluminum foil. None of the plates were observed with tight fitting covers that would make a seal to hold the heat of the food until the time of serving.	F 364		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 19	F 441		

by:
Based on observation and record review, the facility failed to ensure good infection control practice for 2 of 2 residents (R3 and R1) review for infection control, in a sample of 17.

Findings include:

1. R3 has an order for Xeroform and adhesive foam dressing to the pressure sore on the left gluteal fold.

On 11-3-11 at 9:55AM, E3, Assistant Director of Nursing, was observed to change R3's dressing. E3 cut a small piece of Xeroform using a pair of scissors, but failed to clean the scissors prior to cutting. E3 was observed to remove the dressing, which had a small amount of drainage, and put the Xeroform directly on the open pressure sore and then cover with an adhesive foam dressing. E3 failed to remove her gloves and wash her hands between removing soiled dressing and putting on new dressing.

2. R1's Minimum Data Set (MDS), dated 10-16-11, documented diagnosis, in part, as Cerebral Palsy, incontinent of bowel and bladder, total dependence with toileting and extensive assistance with hygiene.

During observation of R1's transfer, on 11-1-11 at 1:55p.m., E6, Certified Nursing Assistant (CNA), and E7 (CNA), transferred R1 from her reclining chair to bed. R1's mechanical lift sling, pants and chair pads were observed soaked in urine and liquid stool. E6 and and E7 did not remove the soiled padding from R1's reclining chair or clean the chair after they provided care and left R1's room. On 11-1-11 at 3:00p.m., the same soiled padding was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20 in R1's chair.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure accurate documentation on the Medication Administration Record (MAR), for 1 of 17 residents (R5) reviewed for documentation in the sample of 17. Findings include: 1. During medication pass on 11-2-2011 at 12:10PM, E4, LPN, failed to give R5 her Alphagan eye drops. According to R5's Physician Order Sheet, POS, R5 is to receive Alphagan 0.1%, 1 drop to right eye three times a day, including noon med pass. On 11-2-11, E4, LPN, initialed she had given the eye drop. When E4 was told she did not give the eye drop during medication pass, E4 looked	F 514		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 21 in the medication cart and could not find the eye drops. E4 stated she should have circled the medication as not given. On 11- 3-2011 at 8:40AM, E2, DON, stated R5 had thought the eye drop had been discontinued. E2 stated she had called the doctor and the eye drop had not been discontinued. E2 confirmed R5 had not been receiving the eye drop. On 11-4-11 at 11:58AM , E2 and E3, Assistant Director of Nursing both stated R5's doctor wants her to have the eye drop. Both stated they did not know if the eye drop was in the facility. Review of R5's Medication Administration Record for November 2011 on 11-2-11 at 2:25PM shows Nursing is documenting they are giving the eye three times a day, when they are not,	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210c) 300.1210d)1)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 22 These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 23 resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on record review and interview the facility failed to assess and monitor 1 of 1 resident (R3) reviewed for constipation in a sample of 17. This failure resulted in R3 being hospitalized with fecal impaction. The facility failed to assess, monitor and treat pain for 1 of 6 residents (R2) reviewed for pain in the sample of 17. This failure resulted in R2 crying with pain. Findings include: 1. It is documented in R3's Hospital and Physical Examination of 9-23-2010, R3 has a diagnosis of Spina Bifida and was hospitalized in the last month for small bowel obstruction. Nurse Practitioner Note of 3-28-11 documents R3 has Chronic Constipation. Hospital History and Physical of 7-26-11 documents R3 's chief complaint is fever, abdominal pain, nausea and vomiting. It is documented under Assessment and Plan, in part, Chronic constipation. Hospital X ray report of 7-26-11 shows mild ileus was seen with the fecal impaction in the colon. Hospital Emergency Department report of 8-7-11	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 24	F9999		

shows R3 was in the Emergency Room with a diagnosis of Constipation. Chief complaint is documented as abdominal pain for 4 days. Much worse today. No bowel movement (BM) for 5 days until yesterday with small hard stool. Past medical history includes small bowel obstruction. Abdomen tenderness, some high pitch and some distention. Clinical Impression is abdominal pain - resolved constipation.

R3's November 2011 Physician Order Sheet (POS) documents a diagnosis, in part, Schizophrenia, Pain, and Constipation. R3 has an order for Morphine Sulfate 15mg daily, Senna Plus twice a day, Bisacodyl 10mg every 8 hours if no bowel movement in 3 days. (Facility BM Tracking Records show the facility is not routinely documenting when R3 has a BM).

R3's Nurses Notes of 8-3-11 states R3 has complaints of constipation and has been refusing Miralax but agreed to take to have a BM. There are no further Nurses Notes addressing BM until 8-6-11 at 2200 stating R3 complaining of abdomen pain but refusing treatment. Large, soft BM noted. Note of 8-7-11 at 1530 documents R3 approached writer with complaint of pain to lower right abdomen that radiates to lower back, is constipated with "rock solid pebbles" in stool. R3 became tearful and stated pain has increased. R3 agreed to be seen by a Doctor and was sent to the ER. Note at 2100 states R3 is back from ER with a diagnosis of Constipation. New order for Mag Citrate one bottle by mouth now and repeat dose tomorrow at bedtime if no good results.

Facility BM Tracking records for August 2011 show no BM recorded until 8-8-11. Records show documentation of 6 BM's in the month of August. BM record for September 2011 show

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 25	F9999		

documentation of 1 BM and October 2011 shows documentation of 3 BM's for the month.

On 11-2-11 at 9:30AM, E2, Director of Nursing (DON) stated R3 is at increased risk for constipation and fecal impaction due to Spina Bifida and taking pain medications.

R2's Minimum Data Set (MDS), dated 9-23-11, documented R2's diagnoses as, in part, Senile Dementia and Schizophrenia and extensive assistance of one person physical assistance with toileting and walking in her room and corridor.

R2's Incident Summary, dated 10-13-11, documented R2 was found on the floor by her roommates bed. It was also documented that R2 had a laceration to the left side of her forehead and a hematoma to her forehead. R2's Incident Summary, dated 10-16-11, documented R2 was found on the floor in her bathroom. It was also documented that R2 was admitted to a local hospital. R2's chart documented R2 was re-admitted to the facility, on 10-20-11, with a fractured right hip.

R2's Pain Screening Form, dated 10-20-11, documented R2's score as a 14 and "score 5 or greater indicates comprehensive assessment needed. R2's Comprehensive Pain Assessment was not dated or completed.

Interview of E11, Care Plan/MDS Coordinator, stated on 11-3-11 at 10:30a.m., R2's Comprehensive Pain Assessment had not been done.

R2's PRN (as needed) Medications sheet, dated 10-20-11 to 11-19-11, documented R2 was administered "Ultram 50mg...pain" 10-26-11 at 1600, 10-27-11 at 1600, 10-28-11 at 12noon and 1600 and 10-31-11 at 12noon. R2's PRN Medications sheet did not document the reason

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 26	F9999		

for administering the medication, site of pain and the result of the medication administration. R2's PRN Medications sheet, dated 11-1-11 to 11-30-11, documented R2 was administered "Ultram 50mg...for pain" on 11-1-11 at 1230 and 1630 and on 11-2-11 at 1545. R2's Nursing Notes, dated 11-1-11 and 1-2-11 and PRN Medication sheet did not document the reason for administering the medication, site of pain and the result of the medication administered.

R2 was observed, on 11-2-11 at 12:00 noon, sitting in the dining room with a weepy, tearing right eye that she repeatedly blinked. R2 was observed until 3:20p.m. repeatedly blinking her right eye which continued to drain.

Interview of R2, on 11-2-11 at 3:20p.m., R2 nodded her head up and down when asked if her right eye hurt. Interview of E7, Certified Nursing Assistant (CNA), on 11-4-11 at 11:05a.m., E7 stated R2 answered questions by nodding her head up and down for yes.

Interview of E8, Licensed Practical Nurse (LPN), on 11-2-11 at 3:20p.m., E8 stated R2's eye was weepy and that R2 indicated she was in pain. E8 also stated she would contact R2's physican. R2's PRN Medication sheet, dated 11-1-11 to 11-30-11, documented R2 was administered "Ultram 50mg..for pain" on 11-23-11 at 1545 but the reason for administering the medication, site of pain and the result of the medication administered. R2's Nursing Notes, dated 11-1-11 to 11-3-11, did not document R2's physician was called for R2's right eye or the effectiveness of the administered medication.

The facility's Pain Management policy and procedure, dated 9-02, documented the first step in pain management was assessment and to assess and documented at regular intervals after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

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F9999	Continued From page 27 initial treatment plan and at suitable interval after each pharmacologic or nonpharmacologic intervention. (B) 300.1010h) 300.1210b) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	F9999		

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	145928	A. BUILDING _____ B. WING _____	11/04/2011

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F9999	Continued From page 28 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on observation, record review and	F9999		

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	145928	A. BUILDING _____ B. WING _____	11/04/2011

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F9999	Continued From page 29	F9999		

interview, the facility failed to revise and implement effective interventions for prevention of repeated falls 3 of 6 residents (R1, R2, R4) reviewed for falls in a sample of 17.

Findings include:

1. On 11/01/11 at 10:23 AM, during the tour of the 100 hall, R4 was observed in his room on the floor in front of the toilet with a wheelchair at his side. E23, Social Services Director, stated that R4 has been getting up on his own and falling lately. R4 was alert, but not oriented, in which E23 reported that is normal for R4. At 10:26 AM, E4, Licensed Practical Nurse, (LPN), assessed R4 for injuries and found no obvious signs of injury. E22 (Restoratives PT) and E6, Certified Nurse Aid, (CNA) then assisted R4 up to wheelchair and transferred R4 to bed. While E6 (CNA) was performing incontinent care, it was observed that R4 had multiple bruises to his left side from the upper ribs down to mid thigh in varying stages of healing. E4 (LPN) stated that the bruises were caused from R4 having so many falls lately. On 11/11/11 at 10:30 AM, E22 stated, "He is supposed to be a walk to dine, but lately I haven't been walking him because he has fallen so much the past few days."

R4 was admitted on 07/18/97 and has medical diagnoses, in part as, dementia, Alzheimer's Disease, epilepsy and seizure. The Minimum Data Set (MDS), dated 08/05/11, identified R4 as moderately cognitively impaired with short and long-term memory deficits, needs extensive assist with at least one staff person for all transfers, ambulation, dressing and hygiene and bathing. It also identified R4 as occasionally incontinent of bowel and bladder. The care plan,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

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F9999	Continued From page 30	F9999		

last updated 08/23/11, identified R4 as an increase risk for falls due to "impaired cognitive and safety awareness...nonambulatory...receive meds which increase risk for falls..." The Falls Risk Assessment, dated 08/05/11, identified R4 scoring 18 points which indicates he is at high risk for falls.

The Fall Prevention Program policy and procedure was reviewed on 11/04/11. Under, "#10. Care incorporates: c. Interventions are changed with each fall, as appropriate, and d. Preventative measures. #12. b. Recommendations for changes in the plan of care to minimize reoccurrence."

On 03/11/11 at 12:30 PM, the Incident Summary documented that R4 was found on the floor by another resident. R4 was found "lying on the floor face lying in blood, blood coming from nose and head." R4 was sent to hospital for treatment for head laceration and left leg pain. There were no new or revised interventions put into place on R4's care plan. On 03/15/11 at 5:55 AM, the Incident Summary documented that R4 was on floor between bed and dresser and wheelchair. The care plan, dated 03/15/11, documented "refer to PT/OT for strengthening."

On 07/16/11 at 11:00 AM, the Incident Summary documented that R4 was found on the floor in his room. It further documented "It appears he was attempting to transfer from chair to bed." The intervention on the care plan, dated 07/16/11, documented "Ensure I am wearing proper footwear before transfers."

On 10/17/11 at 5:30 PM, the Incident Summary documented "Found on floor sitting up..." The intervention, dated 10/17/11, documented "refer to restorative CNA for poss strengthening, P/O (PT Physical Therapy/OT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CHURCH NURSING & REHAB	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

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F9999	Continued From page 31	F9999		

Occupational Therapy)." On 10/24/11, the Incident Summary documented "went to room after eating supper and tried to transfer self, became weak in legs and sat on floor." Interventions documented on the care plan were "PT/OT screen." No new interventions documented on the care plan. On 10/27/11, the Incident Summary documented "Resident roommate informed writer that this resident on floor. Resident sitting on bottom in bathroom with wheelchair behind him." Interventions documented on the care plan for 10/27/11 "PT/OT continue." On 10/30/11 at 5:30 AM, the Incident Summary documented "found on floor between bed and wheelchair. Resident was transferring self. Wheels on wheelchair locked." Interventions on the care plan, dated 10/30/11 "PT/OT."

On 11/01/11, the Incident Summary documented two separate unwitnessed falls. One at 10:23 AM, and the other at 12:30 PM. The Incident Summary documented at 12:30 PM, "observed on floor next to bed trying to lie down." The interventions documented "frequent checks and 72 hour charting."

2. R2's MDS, dated 9-23-11, documented R2's diagnoses as, in part, Senile Dementia and Schizophrenia and extensive assistance of one person physical assistance with toileting and walking in her room and corridor.

R2's Incident Summary, dated 10-13-11, documented R2 was found on the floor by her roommates bed. It was also documented that R2 had a laceration to the left side of her forehead and a hematoma to her forehead. R2's Incident Summary, dated 10-16-11, documented R2 was found on the floor in her bathroom. It was also documented that R2 was admitted to a local

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F9999	Continued From page 32	F9999		

hospital. R2's chart documented R2 was re-admitted to the facility, on 10-20-11, with a fractured right hip.

R2's Care Plan, goal dated 10-31-11, documented R2 was at risk for falls related to self care deficits and impaired cognition and impaired mobility. R2's Care Plan did not document her 10-13-11 and 10-16-11 falls and fall prevention interventions for her falls.

Interview of E3, Director of Nursing (ADON), on 1-3-11 at 9:45a.m., E3 stated R2 was confused and had a history of attempting to ambulate without assistance and self-toileting. Interview of E7, Certified Nursing Assistant (CNA), on 11-4-11 at 11:00a.m., E7 stated R2 had a history of trying to get up and walk around before her falls. Interview of E14 (CNA), on 11-4-11 at 11:05a.m., E14 stated R2 had a history of trying to get up all the time before her falls.

Interview of E11, Care Plan/MDS Coordinator, on 11-3-11 at 9:20a.m., E11 stated R2's Care Plan was in the "down file". E11 provided an updated fall Care Plan on 11-3-11 on placed in R2's Chart. R2's updated fall Care Plan documented R2 was referred to Physical Therapy/Occupational Therapy after her 10-13-11 and 10-20-11 falls. R2's fall prevention Care Plan did not document R2's history of attempting to self ambulating or new interventions to prevent falls as a result of her self ambulating. R2's chart did not document assessments or causative factors of R2 falls.

3. R1's MDS, dated 4-29-11, documented, diagnosis, in part, as Cerebral Palsy, no signs and symptoms of Delirium, no short or long term memory problems, total dependence of two plus

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	145928	A. BUILDING _____ B. WING _____	11/04/2011

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F9999	Continued From page 33 persons physical assistance with transfer and bilateral functional limitation in range of motion for upper and lower extremities. Interview of E3 (ADON), on 11-1-11 at 10:00a.m., E3 stated R1 was reliably interviewable. R1's Preliminary 24-hour Incident Investigation Report, dated 7-5-11, documented R1 complained of right ankle swelling on 7-4-11 a 10:30a.m. and a portable X-ray revealed a fractured of the distal fibula. Interview of R1, on 11-2-11 at 2:35p.m., R1 stated a staff member, name not stated, caught her right foot in her reclining chair during a transfer. She also stated her right foot was broken during the transfer. R1's Final Incident Investigation Report, dated 7-7-11, documented "all nursing staff have been re-inserviced regarding proper transfers include Hoyer lifts, transfers et techniques." (B)	F9999		